DDD – PLAN OF CARE REVIEW FORM INSTRUCTIONS

Purpose: The Individualized Plan of Care is the cornerstone for all waiver services. It should be a thorough representation of the participant's needs, wants, preferences, health, medical and behavioral conditions. Services, supports, and life activities should be person-centered and align with the Division's rules, IPC instructions, and other Division directives. When approving a plan, the Division uses the Medicaid rules in Chapters 41 through 45, Chapter 1 of the DDD rules for case managers, and the performance measures in the waiver documents as approved by CMS July 1, 2009.

Compliance Areas (Per Rule, IPC Instructions, Wvr performance measures)	**Concern Identified and Action Needed** (items Division Staff review)
1. Plan of care submitted on time	Plan submitted within 30-day rule with all accompanying documentation. Late plans are referred to Survey/Cert for the CM's certification file, unless the waiver specialist excuses the tardiness or exception to the rule.
2. Pre-Approval form is accurate and within IBA	Name, SSN, b-date, and plan date are checked for accuracy. Service lines should be within IBA and have correct codes, historical units, and current rates. Items listed here need correction. NOTE: After separate case manager NPI #s go into effect, check that CM name and number is on top and organization CM NPI # is on service line.
3. Plan contains all identified documents for participant's services and needs	Plan submitted is compared to the Technical Checklist to make sure all documents are in the packet. Missing pieces are listed here. Plan is not reviewed until all pieces are submitted. In this case, the review form will be sent with only concerns found to this point.
4. LT-MR-104/ABI-105 Correct	LT-MR-104/ABI-105 received with plan, screening within 365 days, meets criteria for ICF/MR level of care.
5. Meets ICF/MR Level of Care	The information on the LT-MR-104 or LT-ABI-105 meets the criteria for ICF/MR level of care. Division staff signs the form.
6. Plan includes necessary signatures	Signatures on all pages must be present. If no signature is found, then a concern is identified and the review form sent up to this point. Plan is not reviewed unless there is an exceptional reason for the missing signature. Document the reason on this form if it is acceptable and develop a timeline for the case manager to submit the signatures to DDD before the plan is approved.
7. Eligibility assessments are current and qualify	Psych and ICAP must be within required timelines, contain eligible diagnosis, and ICAP scores. WS completes eligibility worksheet as needed if there are questions regarding eligibility. If assessments are out of date, identify the compliance and set a deadline for submission of a new assessment. If current assessment shows the participant is ineligible, then work the waiver manager on notifying the participant of ineligibility for the waiver.
8. About Me is person-centered and thoroughly answers questions	Answers should follow the questions and italics. Objective progress shall be listed. Personal goals listed. Ask CM for more information where needed.
9. Demographics page complete and accurate	Numbers are checked with MMIS, preapproval, LT-MR-104/105 for consistency. Physical address shall not be the P.O. Box, or provider's main address (unless it is accurate.) list concerns or inconsistencies here. Make sure at least 3 boxes are checked in functional limitations.
10. Each Right Restriction applicable to the participant addresses all requirements	Each right restricted for a participant includes the reason, how it is imposed and a plan to exercise the right to its fullest. Concerns in this area must be identified, such as a restriction in the PBS that is not listed on the rights page.
11. Services chosen reflect preapproval form	Services available page must have all applicable boxes checked pertaining to services on preapproval form. If other parts of plan list services not listed on this page, identify those concerns here.
12. Non-waiver services are listed that help cover participant's needs	Non-waiver services should be marked or listed as applicable for the participant. Compare information to MMIS, demographic page, about me answers, etc. WS may recommend a non-waiver service if one is not listed

	that should be available to the participant.
13. Medical Services	Medical Services are filled out with all applicable services noted. Recommendations are listed and reflected elsewhere in plan or on schedules as needed. Last and next visits are listed. If a service is being considered, an action plan is listed in the recommendations area.
14. Medical Information	Information is listed completely and is updated as needed. Page could be used when emergency services are accessed for a participant. Medication info shall be listed thoroughly with all requested fields of information. Some situations may need to be referred to APS Healthcare to review medical treatments or medication regimens.
15. Medication Assistance	All assistance a participant needs to successfully take medications or get to medical appointments shall be listed. The IPC Instructions detail directions on filling out this new section thoroughly.
16. Protocols (Seizure, Medical)	Address protocols for seizures, medical reasons, or medication in a manner that details how to perform each step, warnings, side effects, etc. Some situations may need to be referred to APS Healthcare for review.
17. Plan identifies health and safety risks in each area	Address concerns relating to all risk areas: medical, transportation financial, mobility, behaviors, home safety, etc. Risks may be identified in Psych eval, ICAP, by team members, or from previous plans.
18. Plan addresses risks through appropriate supports and accommodations	If a risk is identified in an area on the plan, but a safety plan is not included or is inadequate, then the area of risk is identified here along with the problem with the safety plan. Safety plans should be in place for each risk identified, even though the participant may not comply with all safety plans all of the time.
19. Plan describes participant's supervision thoroughly and in various settings	This question replaces the "supports" boxes, so response shall be detailed and fully describe the supervision needed in various settings…including when a person can have NO supervision.
20. Positive Behavior Support Plan complies with Ch 45 Sec 29	ICAP, psych, and about me checked to see if Positive Behavior Support (PBS) plan Is required. If not, problem addressed here. If PBS plan is included, use Ch 45, Sec 29 to ensure the PBS plan meets criteria in our rule. If concerns are found, reference the rule and section of PBS plan that is concerning and explain the action needed to make the PBS plan in compliance.
21. Restraint information complies with Ch 45 Sec 28	If a restraint is listed in the Rights page or in the PBS plan, then it must comply with Ch 45, Sec 28. It needs an order, other less restrictive measures listed, face to face evaluator identified, and contain other items in rule.
22. Objectives are S.M.A.R.T. and includes task analysis	Objectives for each service must meet SMART model. If not, list which letter-and word is not met by the objective. A task analysis is required, so it may be on a separate form or on the schedule. It must meet the definition of T.A. in the IPC instructions. Services may have multiple objectives. Broad methodology under a narrow objective allows for an objective to be run in various ways and settings. Measurement criteria are necessary for the T.A. and overall measurement of progress. If a "Circle of Support" is needed, the components must follow the IPC Instructions.
23. Schedules comply with Ch 45 Sec 27 and IPC instructions	Schedules must meet requirements in rule and in IPC instructions. They shall reflect activities in the About Me section and align with supports listed elsewhere in the plan.
24. Service Forms include all necessary information	Service forms shall have accurate descriptions of the service, detailed recommendations, invoices, and/or training components. Skilled nursing forms must include only medically necessary services. Must have physician signature, units listed, and expiration date.

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25. Plan verifies participant/guardian participated in development of the plan	On the Participant/Guardian Verification Form in IPC, if signatures were not affixed to plan, but box is marked, then require proof that the participant and/or guardian were a part of developing the plan. If no proof is submitted, then the plan cannot be approved.
26. Rights restrictions were explained and agreed to by the participant/guardian	Verification similar to box above. If "no" is marked then there must be an explanation submitted. If there is no explanation or an inadequate explanation, then the plan cannot be approved until they are explained, changed, and agreed upon by the participant/guardian or a reasonable explanation is accepted by the Division.
27. Plan includes verification of choice offered to participant/guardian	Verification similar to box above. If "no" is marked, refer the matter in IMPROV to Survey/Certification and an ARS to look into. Not offering choice is a case manager/provider compliance issue and must be followed up. Do not approve a plan if choice was not offered, unless otherwise approved by a DDD manager.
28. Adequate conflict of interest safeguards in place	If a conflict applies, does the plan have a fair and adequate way for the participant/guardian to address issues or concerns they have. Does the section address the conflict with a checks and balance system in place to protect the participant? Do not approve plans that do not adequately address the conflict of interest.
29. Plan reflects personal goals identified in "About Me"	Concerns in this area will be visible after whole plan is reviewed. If objectives, supports, reinforcements, activities and schedules do not reflect personal goals, then address those items in this section.
30. Services and supports align with participant's assessed needs	The needs identified in assessments, about me, risk areas, supports sections, and in PBS plan shall align with the services chosen on the plan and non-waiver services listed. Concerns with "over-serving" or "under-serving" a participant shall be listed here, if another service should be used instead of the one listed on the plan.
31. Unmet needs identified	Unmet needs may be identified in various places on the plan or in assessments. Some may be discussed at a team meeting. If an unmet need is identified by the CM or DDD, then an action plan shall be submitted to address the unmet need.
32. Unmet needs addressed	An unmet need can be addressed through working with other agencies, team members, community groups, natural supports, or by accessing other Medicaid/Medicare services. Some unmet needs are difficult to meet, but the CM should always have an action plan for continuing to try to meet needs
Other Plan Corrections or Comments	Division staff may list other concerns resulting in non-compliance with rule or the IPC Instructions. If the concern does not need action or identify a compliance issue, it should not be included in this box.